STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/24/2012

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RITTENHOUSE SENIOR LIVING OF INDIANAPOLIS	1251 W 96TH ST INDIANAPOLIS, IN 46260

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R0000	This visit was for a State Residential Licensure Survey. Survey dates: July 23 & 24, 2012 Facility number: 003282 Provider number: 003282 AIM number: N/A Survey team: Christi Davidson, RN-TC Diana Zgonc, RN Lora Brettnacher, RN Census bed type: Residential: 76 Total: 76 Census payor type: Other: 76 Total: 76 Sample: 7 These state findings are cited in accordance with 410 IAC 16.2. Quality review 7/27/12 by Suzanne Williams, RN	R0000	DISCLAIMER:Preparation and implementation of this plan of correction does not constitute admission or agreement by Rittenhouse Senior Living of Indianapolis of the truth of the facts, findings, or other statements as alleged by the preparer of the survey/inspection dated July 24, 2012. Rittenhouse Senior Living of Indianapolis specifically reserves the right to move to strike or exclude this documents as evidence in any civil, criminal or administrative action not related directly to the licensing and/or certification of this facility or provider.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview the facility failed to immediately consult with a resident's physician regarding a change in the resident's psychosocial and mental status and regarding an allegation of sexual abuse voiced by the resident for 1 of 7 residents reviewed for physician notification. (#48) Findings include: The record for Resident #48 was reviewed on 7/24/12 at 2:00 p.m. Diagnoses included, but were not limited to dementia, Alzheimer's disease, hypertension, and osteoarthritis. A facility reportable and investigation provided by the Executive Director on 7/23/12 at 11:30 a.m. indicated Resident #48 had reported an allegation of sexual abuse from a staff member to her family during a visit home on 11/24/11. The	R0036	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:The staff member responsible for physician notification in this specific instance is no longer employed by the facility. All Licensed Nurses shall receive in-service education regarding the facility "Notification Policy - Physician, Resident, and Responsible Parties". In addition a checklist shall be developed regarding all steps to be followed with regard to any reportable occurrence, including timely notification to all required parties. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:All residents have the potential to be affected.3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:The Licensed Nurses shall receive in-service	09/10/2012

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	family member reported the allegation to the Marketing Director on 11/25/11 when the resident was returned to the facility. The investigation indicated, "...in an effort to observe the resident's behavior/reactions, specifically anxiety or a specific reaction to any one person on the unit. Upon entering the memory care unit...When he acknowledged the resident...the resident immediately put her eyes to the ground and stated 'no'. Resident began to become upset and tearful and was escorted to the nursing office for privacy and comforting...The resident repeated this phrase several times and then proceeded to say 'it was terrible'. At this time the resident was given her morning medications, including Clonezapam [anti-anxiety]...then escorted...where her son was waiting...11/28/11 - Memory Care Director conducts interview with resident who recants same story as was told to family and staff member on Friday 11/25/11...Resident began to cry...Resident then began making repetative (sic) statements about wanting to die and not wanting to be here anymore...Most important concern following this interview is residents repeated comments about wanting to die...11/29/11 - Director faxed resident's attending physician regarding concerns with medication. Physician's nurse called		education to include the facility policy "Notification Policy - Physicians, Residents, and Responsible Parties" along with the newly implemented checklist for required notifications following a reportable occurrence. This training shall also include proper documentation in the clinical record of these notifications.Licensed Nurses who do not follow the "Notification Policy" correctly shall receive disciplinary action in the form of a written reprimand and potential for termination from their position should there be any re-occurrence.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:The Resident Care Director, or her designee, will audit the clinical records of any resident(s) with a reportable occurrence to ensure compliance with the facility policy "Notification Policy". These audits will be performed on every occasion of a reportable occurrence and a log shall be kept of the results of the audit. Audits of reportable occurrences shall be on going.5) By what date the systemic changes will be completed:Date of completion: 9/10/2012.	

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	and indicated the Dr. would like the resident sent out to be evaluated and treated as soon as possible...." During an interview on 7/24/12 at 9:17 a.m., the Executive Director indicated she was notified by the manager on duty on 11/25/11 regarding the sexual abuse allegation involving Resident #48. She indicated on a conference call, the alleged staff member was suspended until an investigation was completed. The Executive Director was asked if the physician was notified and if the resident had a physical exam immediately upon becoming aware of the sexual abuse allegation on 11/25/11. The Executive Director indicated she would look for documentation. During an interview on 7/24/12 at 11:00 a.m., the Executive Director indicated the physician was notified on 11/29/11. The Executive Director indicated the facility lacked documentation of immediate physician notification and lacked documentation of a physical exam conducted immediately after the facility became aware of the sexual abuse allegation. A facility policy provided by the Executive Director on 7/23/12 at 11:25 a.m., titled, "Abuse Prohibition," dated			

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	8/20/2008, indicated, "...Upon receiving information concerning a report of abuse, the Executive Director or designee will...conduct an immediate and thorough investigation [underlined] which will focus on...A clinical examination for signs of injuries, if indicated...."			

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R0090	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be			

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	available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to notify the Indiana State Department of Health within 24 hours of becoming aware of a sexual abuse allegation and an incident of resident to resident altercation for 2 of 3 abuse and/or abuse allegation reportables reviewed. (#48, #49) Findings include: 1. During an interview on 7/23/12 at 9:25 a.m., the Executive Director was requested to provide three facility reportables involving abuse and/or abuse allegations for review. A facsimile transmittal sheet indicated, "...TO: ISDH...DATE: 11/28/11...Subject: Reportable Occurrence...." The reportable indicated the date of the incident was 11/23/11 and involved Resident #48. The facility reportable provided by the Executive Director on 7/23/12 at 11:30 a.m. indicated Resident #48 had reported	R0090	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Effective immediately the Executive Director, or her designee, will submit the report of all unusual occurrences within 24 actual hours of the report of the occurrence. While the paperwork in this instance was not submitted within 24 actual hours, the accused staff member was immediately suspended from his position and did not return to the facility until the investigation into the incident was complete.2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:All residents have the potential to be affected.3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:The Executive Director, or her designee, will immediately begin submitting all unusual occurrences within 24 actual hours of the occurrence. 4) How the corrective action(s) will be monitored to ensure the	08/10/2012

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	an allegation of sexual abuse from a staff member to her family during a visit home on 11/24/11. The family member reported the allegation to the Marketing Director on 11/25/11 when the resident was returned to the facility. During an interview on 7/24/12 at 9:17 a.m., the Executive Director indicated she was notified by the manager on duty on 11/25/11 regarding the sexual abuse allegation from Resident #48. She indicated she was "misinformed" and thought she had 24 hours with regard to business days for reporting unusual occurrences to the state agency. 2. During an interview on 7/23/12 at 9:25 a.m., the Executive Director was requested to provide three facility reportables involving abuse and/or abuse allegations for review. A facsimile transmittal sheet indicated, "...TO: ISDH...DATE: 4/9/12...Subject: Reportable Incident...." The reportable indicated the date of the incident was 4/7/12 and involved Resident #48 and Resident #49. The facility reportable provided by the Executive Director on 7/23/12 at 11:30 a.m. indicated, "Both residents were arguing loudly in hallway. As the Nurse		deficient practice will not recur, i.e. what quality assurance program will be put into place:The Resident Care Director shall review the submission of all unusual occurrences for the first three months following acceptance of the Plan of Correction to ensure timely submission. Results of this review shall be documented. Following this three month period the Executive Director, or her designee, will be responsible to submit all unusual occurrences within 24 actual hours of occurrence.5) By what date the systemic changes will be completed:Date of completion: 8/10/2012.	

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	tried to separate them resident, [name of Resident #48], hit resident, [name of Resident #49], in the face. Resident, [name of Resident #48], then pushed Nurse backward causing Nurse to lose balance...." During an interview on 7/24/12 at 9:17 a.m., the Executive Director indicated she was "misinformed" and thought she had 24 hours with regard to business days for reporting unusual occurrences to the state agency. A facility policy provided by the Administrator on 7/23/12 at 11:25 a.m., titled, "Abuse Prohibition," dated 8/20/2008, indicated, "...Rittenhouse Senior Living Assisted Living Communities will prohibit abuse...through the following...Reporting of incidents...Upon receiving information concerning a report of abuse, the Executive Director or designee will:...Report it to appropriate agencies as per state requirement...."			

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R0148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on record review and interview the facility failed to have the heating and ventilating system inspected yearly. This would potentially affect all the residents. Findings include: During an environmental tour on 7/24/12 at 2:00 p.m., Maintenance Staff #2 indicated the heating and cooling systems were not inspected yearly. Maintenance Staff #2 indicated when a problem occurs the mechanical service company used by the facility was called to make repairs. The Maintenance Staff #2 indicated he changes the filters every three months. He indicated the business office maintained the invoices from the repairs	R0148	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:The facility shall have all HVAC equipment inspected and shall continue to have all HVAC equipment inspected annually thereafter.2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:All residents have the potential to be affected.3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:Annual inspection of HVAC equipment will be added to the facility's written preventive maintenance schedule.4) How	08/31/2012

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	and service calls to the heat and air units. Maintenance Staff #2 indicated the facility had 11 air units and 13 heat units. On 7/24/12 at 1:25 p.m., the Business Office Manager was requested to provide service documents from September 2011 through present for the heating and air systems. On 7/24/12 at 1:30 p.m., Maintenance Staff #2 provided service records from the mechanical service company dated 12/16/11 for no heat, and 6/20/12 for not cooling. The job invoice dated 6/20/12 indicated, "...Responded to no cool...Both unit EXTREMly (sic) Dirty (sic) and in dire need of cleaning as well as both units should have contactors replaced...Units Are (sic) in NEED (sic) of Immediate (sic) Attention (sic)...." During an interview on 7/24/12 at 1:30 p.m., the Executive director indicated the inspection for the heating and air was done internally by the facility maintenance staff. The Executive Director indicated the Maintenance staff were not certified in heating and air.		the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.Annual inspection of HVAC equipment will be added to the written preventive maintenance schedule. The Maintenance Director will be responsible to ensure inspections are scheduled and implemented no less than annually. The Executive Director shall be responsible to monitor compliance to the written preventive maintenance schedule by the Maintenance Director.5) By what date the systemic changes will be completed:Date of Completion 8/31/2012.	

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R0151	410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on record review and interview the facility failed to ensure a resident's cat was current on vaccinations for 1 of 3 cats that currently reside in the facility. (#83) Findings include: During the entrance conference on 7/23/12 at 8:40 a.m., the Executive Director indicated there were three cats residing in the facility. The facility pet policy was requested from the Executive Director. On 7/24/12 at 9:00 a.m., a facility binder containing vaccination records for facility pets and pets that visit the facility was reviewed. A Certificate of Vaccination for Resident #83's cat, indicated, "...Date of Rabies Vaccination: 03-10-11...Next Rabies Vaccination On: 03-09-12...Species: Feline...." During an interview on 7/24/12 at 9:13 a.m., the Executive Director indicated Resident #83's cat currently lived in the facility. Documentation of the cat's current vaccinations that were due 3/9/12 was requested from the Executive	R0151	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:The cat in question was taken by the resident's family to the Veterinarian on 7/26/12. The vaccination records for this cat have been provided to the facility and are now on file in the facility Pet Vaccination binder.2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:All residents have the potential to be affected.3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:A new Pet Vaccination Procedure was put into place to be followed by the staff member(s) responsible for monitoring pet vaccinations. Implementation of this procedure shall prevent re-occurrence. 4) How the corrective action(s) will be monitored to ensure the deficient proactice will not recur, i.e., what quality assurance program will be put into place:Monthly calendars have been added to the Pet Vaccination binder listing the	08/10/2012

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	Director. During an interview on 7/24/12 at 1:30 p.m., the Executive Director indicated the family of Resident #83 was requested by the Executive Director to fax to the facility the current vaccination records for the resident's cat. As of the exit conference on 7/24/12 at 4:50 p.m., the facility lacked documentation of current vaccination records for Resident #83's cat. A facility policy provided by the Executor Director on 7/23/12 at 9:25 a.m., and titled, "Pet Policy," and dated 08/20/2008, indicated, "...Proof of shots (including proof of rabies vaccination) will be provided for the Community files...."		vaccination due date of each pet residing in the facility. The Pet Vaccination binder is to be reviewed a minimum of two times per month with a reminder call placed to the resident's responsible party a minimum of 30 days prior to the pet's vaccination expiring. Reminder calls to the responsible party of the resident shall be documented on the vaccination calendar. The Business Office Director shall be responsible to monitor the Pet Vaccination Binder to ensure compliance and prevent re-occurrence.5) By what date the systemic changes will be completed:Date of completion: 8/10/2012.	

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R0214	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview the facility failed to provide a semi annual service plan for 1 of 7 residents reviewed for service plans. (#101) Findings include: The closed record of Resident #101 was reviewed on 7/24/12 at 10:00 a.m. Diagnoses included, but were not limited to neuropathy, mood disorder, depression and hypertension. The record indicated Resident #101 was transferred out of the facility on 4/28/12. The most current service plan in the closed record was dated and signed by the Executive Director on 08/10/11. During an interview on 7/24/12 at 1:30 p.m., an updated semi annual service plan was requested for Resident #101 from the Executive Director.	R0214	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:All current resident medical records shall be reviewed to ensure all records have an updated service plan in place with no service plan exceeding the semi-annual requirement. 2) How the facility will identify other residents having the potential to be affected by the same dficient practice and what corrective action will be taken:All residents have the potential to be affected.3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:Staff member(s) responsible for completion of resident Servvice Plans will follow an audit checklist that has been developed to ensure resident Service Plans are completed in a timely manner per regulation.4) How the corrective actiion(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:The	09/10/2012

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		A. BUILDING 00 B. WING	07/24/2012

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	As of the exit conference on 7/24/12 at 4:50 p.m., the facility lacked documentation of an updated semi annual service plan for Resident #101.		audit checklist developed will be completed by the staff member assigned and reviewed by either the Resident Care Director or the Director of Memory Care monthly, ongoing.5) By what date the systemic changes will be completed:Date of Completion: 9/10/2012.	

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R0240	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to ensure personal care, and assistance with activities of daily living were provided based upon individual needs and preferences for 1 of 7 residents reviewed for service plans being implemented (Resident #48). Findings include: Resident #48's record was reviewed on 7/23/2012 at 2:00 P.M. Resident #48 was admitted to the facility on 11/1/2011 and had current diagnoses which included dementia and Alzheimer's with agitation. Nurse's notes from admission on 11/1/2011 through 11/24/2011 were reviewed. A nurse's note dated 11/1/2011 indicated Resident #48 had zero behaviors. A nurse's note dated 11/2/2011 indicated Resident #48 was very relaxed and adjusting well to the facility. A nurse's note dated 11/10/2011 indicated Resident #48 was very anxious and complained of a headache. No further documentation of Resident #48 adjusting/not adjusting or having behaviors/not having behaviors were	R0240	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:The Service Plans for all residents shall be reviewed with emphasis given to individual needs and preference. If provisions are not already in place to accommodate the needs or preferences of each resident, procedures shall be put into place to accommodate those requests.2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:All residents have the potential to be affected. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:Resident Service Plans shall be audited to ensure needs and preferences correspond with the caregiver Assignment Sheets for each resident.4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.Monthly audits of caregiver Assignment Sheets shall be performed by either the	09/10/2012

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	noted prior to 11/25/2011. A nurse's note dated 11/25/2011 at 11:00 A.M. indicated, " Res. (resident) entered the nurses station crying historically (sic). Tried to calm res. down. Res crying upon entrance back on to the unit. Res. given Clonezapam. Writer and (staff named) calmed and comforted res (sic). will continue to monitor res (sic) for further behavioral changes." A nurses note dated 11/25/2011 at 5:00 P.M. indicated, "Resident starts to tell nsg (sic) something that was hard to understand. She began to cry and was calmed down and sat @ dinner table. No further crying spells this shift." A nurse's note dated 11/26/2011 at 2:00 P.M. indicated, "Resident calm most of shift. Resident's sister in to visit resident. Stated she doesn't want any male care givers. I ask why. Resident couldn't explain and begin to cry. Resident directed to sing along activity and seemed to enjoy herself will continue to monitor." An interdisciplinary progress note dated 11/25/2011 indicated while Resident #48 was visiting her family at home the family called the facility to voice a concern. The Executive Director was notified of the concern. The family was told an investigation would be completed and the		Resident Care Director or Director of Memory Care ongoing.5) by what date the systemic changes will be completed:Date of Completion: 9/10/2012.	

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	male care giver would be removed from the building. Resident #48 was not to have any male care givers until further notice and the family would be keeping the resident over night. Review of the investigation report form indicated Resident #48's son came into the facility on Friday November 25, 2011 and discussed his concern with the Marketing Director. He reported, ". . . after picking up his mother to take her home for Thanksgiving dinner, he and other family members noticed her to be very quiet and withdrawn, acting as if something was bothering her. Upon inquiry by the family the resident told her family that a black man had touched her and pushed on her stomach and had his hands in her pants. The resident stated to her family that she repeatedly said "I cant have a baby"." The resident's son began questioning her about the details. At this time he decided to keep his mother overnight at his home and return her to the facility the following day. This incident note further indicated, "Upon return to the facility on Friday, Nov 25, 2011, resident was escorted to the Memory Care Unit where she lived by (staff named) in an effort to observe the resident's behavior/reactions, specifically anxiety or a specific reaction to any one person on the unit. Upon entering the			

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	Memory Care Unit, there was a black, male staff member standing in another resident's doorway. When he acknowledged the resident by saying hi, the resident immediately put her eyes to the ground and stated "no". Resident began to become upset and tearful and was escorted to the nursing office for privacy and comforting. The resident was asked why she had stated "no" and the resident responded "he did that to me, I don't know why he did that to me." The resident repeated this phrase several times and then proceeded to say "It was terrible." When asked "what was terrible" the resident stated, "he put his fingers on my private and he pushed in.' During this comment resident demonstrated with her own hands what she meant (outside of clothing). Resident was then escorted back to the memory care unit where her son was waiting." A nurse's note dated 11/29/2011 indicated Resident #48 had been making statements about wanting to die and not having a reason to live. The resident's son was notified and he requested a psychiatric evaluation. Review of a psychiatric note dated 11/29/2011 indicated Resident #48, ". . .here from Rittenhouse Assisted Living because of increasing agitation, delusions, false accusation, and aggression. She is anxious and			

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	sundowning. Information sources, for the summary, come from an examination of the patient, who is a poor historian as well as information obtained from the facility. . .She apparently has fairly advanced stage dementia. . .she has been talking about wanting to die and she accused a male staff member of touching her sexually. . . judgement and insight fair oriented only to person. . . medication changed. . ." Review of a current service plan originally dated 1/9/2012 indicated Resident #48 had accused staff of inappropriate touch and female care givers were preferred. During an interview on 7/24/2012 at 10:50 A.M., LPN (Licensed Practical Nurse) #1 indicated Resident #48 currently had male care givers including the male care giver who was accused of inappropriately touching her. When it first happened they did not allow male staff to care for her but after Resident #48 returned from the psychiatric evaluation and the facility's investigation of the allegations determined the resident's statements could not be verified, male care givers were assigned to care for her. Documentation was requested and not available of exactly when male care givers were allowed to care for Resident #48 again. Documentation of			

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	assessments were requested and not available regarding Resident #48 not preferring female care givers. During this interview on 7/24/2012 at 10:50 A.M., the Memory Care Director indicated she had not updated the service plan because she had not been at the facility very long. She could not provide documentation of exact dates or assessments requested. During an interview on 7/24/2012 at 11:05 A.M., the Executive Director (ED) indicated the facility did not have documentation of Resident #48 being reassessed regarding her preference for female care givers however male care givers were taking care of Resident #48, She indicated since they changed Resident #48's medicine she no longer exhibited fear of male care givers. Certified Nursing Assistant Assignment sheets were requested at this time. The ED indicated they may have them for the last three months but not back in November or December of 2011. None were provided.			